Department of HUMAN SERVICES

Integrated Health Home Workgroup Meeting April 27, 2022

April 27, 2022

Role Call

Format of Workgroup

- Discuss prior meeting (high level)
- Topic for the meeting
- Plan and expectations for next meeting

It is ok to ask questions during the meeting and between meetings. These questions and answers will be shared at the beginning of each meeting.

What is Our Why? What Do We Want to Accomplish?

- Identify how the Health Homes meet the provider standards set forth by the federal government as well as identify appropriate oversight of those standards.
- Develop a proposal for a payment methodology that is consistent with the goals of efficiency, economy, and quality of care. The rate will be developed according to the actual cost of providing each component of the service.
- Review member qualifications in order to propose qualifications that meets federal and state code.
- Update Health Home Services to reflect whole-person team based-care while reducing provider burden.
- Develop a Quality Improvement model that can be adopted by Integrated Health Homes.
- Develop a proposal to present to the State that encompasses all the forementioned goals.

Ground Rules

- You can respect another person’s point of view without agreeing with them.
- Respectfully challenge the idea, not the person and bring potential solutions.
- Blame or judgment will get you further from a solution, not closer.
- Honest and constructive discussions are necessary to get the best results.
- Listen respectfully, without interrupting.
- Listen actively and with an ear to understanding others' views. (Don’t just think about what you are going to say while someone else is talking.)
- Commit to learning, not debating. Comment in order to share information, not to persuade.
- Avoid blame, speculation, and inflammatory language.
- Allow everyone the chance to speak.

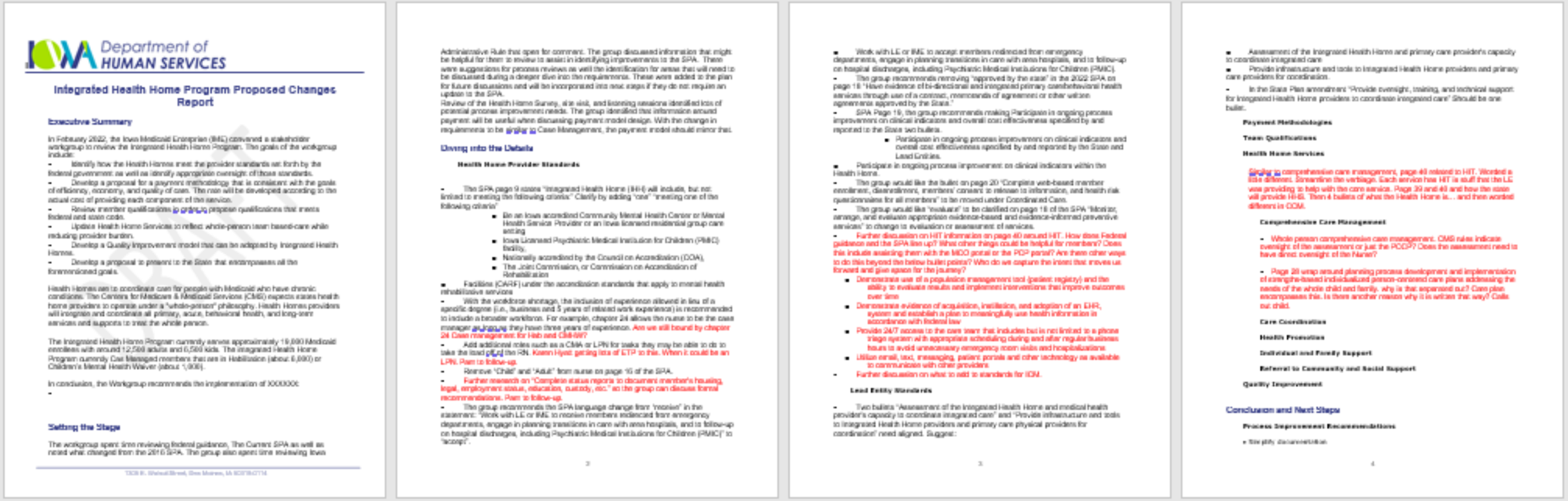
Objectives

- Review of Last Meeting and Workgroup Report
- Continue Provider Standards Deep Dive
  - Health Information Technology
  - Habilitation and CMH Waiver
- Payment Methodologies
  - Health Home Services documentation on the claim.
- Member Qualifications
  - MCO/IME Support of Provider Enrollment Activities
  - How does CMH and Habilitation fit into this?
  - Address the LMHP requirement for FI (propose recommendations)
    - Multiple ask for records, incomplete records, refusing to share records.
    - Causes an access to Health Home Services barrier
    - Health Home doesn't want to turn away eligible members
    - Causing provider abrasion between LMHP and HH
    - Creates bottleneck
- Team Qualifications
  - Peer Training (age requirement, additional training, support needs of the IHH)

Last Meeting

- Completed brainstorming activity questions to assist in creating robust discussions.
- Questions/Answers

Workgroup Report



Department of HUMAN SERVICES

Integrated Health Home Program Proposed Changes Report

Executive Summary

In February 2022, the Iowa Medicaid Enterprise (IME) convened a stakeholder workgroup to review the Integrated Health Home Program. The goals of the workgroup include:

- Identify how the Health Homes meet the provider standards set forth by the federal government as well as identify appropriate oversight of those standards.
- Develop a proposal for a payment methodology that is consistent with the goals of efficiency, economy, and quality of care. The rate will be developed according to the actual cost of providing each component of the service.
- Review member qualifications to ensure proposed qualifications that meets federal and state code.
- Update Health Home Services to reflect whole-person team based-care while reducing provider burden.
- Develop a Quality Improvement model that can be adopted by Integrated Health Homes.
- Develop a proposal to present to the State that encompasses all the forementioned goals.

Health Homes aim to coordinate care for people with Medicaid who have chronic conditions. The Centers for Medicare & Medicaid Services (CMS) expects state health home providers to operate under a "whole-person" philosophy. Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

The Integrated Health Home Program currently serves approximately 19,000 Medicaid enrollees with around 12,500 adults and 6,500 kids. The Integrated Health Home Program currently Civil Managed members that are in Habilitation (about 6,000) or Children's Mental Health Waiver (about 1,000).

In conclusion, the Workgroup recommends the implementation of XXXXXXX

-

Setting the Stage

The workgroup spent time reviewing federal guidance, The Current SPA as well as noted what changed from the 2016 SPA. The group also spent time reviewing Iowa

Administrative Rule that open for comment. The group discussed information that might be helpful for them to review to assist in identifying improvements to the SPA. There were suggestions for process reviews as well the identification for areas that will need to be discussed during a deeper dive into the requirements. These were added to the plan for future discussions and will be incorporated into next steps if they do not require an update to the SPA.

Review of the Health Home Survey, site visit, and licensing sessions identified lots of potential process improvement needs. The group identified that information around payment will be useful when discussing payment model design. With the change in requirements to be going to Case Management, the payment model should mirror that.

Diving into the Details

Health Home Provider Standards

- The SPA page 9 states "Integrated Health Home (IHH) will include, but not limited to meeting the following criteria:" Clarify by adding "one" "meeting one of the following criteria"
  - Be an Iowa accredited Community Mental Health Center or Mental Health Service Provider or an Iowa licensed residential group care setting
  - Iowa Licensed Psychiatric Medical Institution for Children (PMIC) facility,
  - Nationally accredited by the Council on Accreditation (COA),
  - The Joint Commission, or Commission on Accreditation of Rehabilitation
- Facilities (CARF) under the accreditation standards that apply to mental health rehabilitative services
- With the workforce shortage, the inclusion of experience allowed in lieu of a specific degree (i.e., business and 5 years of related work experience) is recommended to include a broader workforce. For example, chapter 24 allows the nurse to be the case manager as long as they have three years of experience. Are we still bound by chapter 24 Case Management for Hab and CMHW?
- Add additional roles such as a CMA or LPN for tasks they may be able to do to take the load off the RN. Karen Hyatt getting lots of LTP to this. When it could be an LPN. Pam to follow-up.
- Remove "Child" and "Adult" from nurse on page 16 of the SPA.
- Further research on "Complete status reports to document member's housing, legal, employment status, education, custody, etc." so the group can discuss formal recommendations. Pam to follow-up.
- The group recommends the SPA language change from "receive" in the statement: "Work with LE or IME to receive members referenced from emergency departments, engage in planning transitions in care with area hospitals, and to follow-up on hospital discharges, including Psychiatric Medical Institutions for Children (PMIC)" to "accept".

- Work with LE or IME to accept members redirected from emergency departments, engage in planning transitions in care with area hospitals, and to follow-up on hospital discharges, including Psychiatric Medical Institutions for Children (PMIC).
- The group recommends removing "approved by the state" in the 2022 SPA on page 18 "Have evidence of bi-directional and integrated primary care/behavioral health services through use of a contract, memoranda of agreement or other written agreements approved by the State."
- SPA Page 19, the group recommends making Participate in ongoing process improvement on clinical indicators and overall cost effectiveness specified by and reported to the State two bullets.
  - Participate in ongoing process improvement on clinical indicators and overall cost effectiveness specified by and reported by the State and Lead Entities.
- Participate in ongoing process improvement on clinical indicators within the Health Home.
- The group would like the bullet on page 20 "Complete web-based member enrollment, disenrollment, members' consent to release to information, and health risk questionnaires for all members" to be moved under Coordinated Care.
- The group would like "evaluate" to be clarified on page 18 of the SPA "Monitor, arrange, and evaluate appropriate evidence-based and evidence-informed preventive services" to change to evaluation or assessment of services.
- Further discussion on HIT information on page 40 around HIT. How does Federal guidance and the SPA line up? What other things could be helpful for members? Does this include assisting them with the MCO portal or the PCP portal? Are there other ways to do this beyond the below bullet points? Who do we capture the intent that moves us forward and give space for the journey?
  - Demonstrate use of a population management tool (patient registry) and the ability to evaluate results and implement interventions that improve outcomes over time
  - Demonstrate evidence of acquisition, installation, and adoption of an EHR, system and establish a plan to meaningfully use health information in accordance with federal law
  - Provide 24/7 access to the care team that includes but is not limited to a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations
  - Utilize email, text, messaging, patient portals and other technology as available to communicate with other providers
- Further discussion on what to add to standards for IDN.

Lead Entity Standards

- Two bullets "Assessment of the Integrated Health Home and medical health provider's capacity to coordinate integrated care" and "Provide infrastructure and tools to Integrated Health Home providers and primary care physical providers for coordination" need aligned. Suggest:

- Assessment of the Integrated Health Home and primary care provider's capacity to coordinate integrated care
- Provide infrastructure and tools to Integrated Health Home providers and primary care providers for coordination.
- In the State Plan amendment "Provide oversight, training, and technical support for Integrated Health Home providers to coordinate integrated care" Should be one bullet.

Payment Methodologies

Team Qualifications

Health Home Services

Similar to comprehensive care management, page 40 released in HIT. Worded a little different. Streamline the verbiage. Each service how HIT is stuff that the LE was providing to help with the care service. Page 39 and 40 and how the state will provide HHS. Then 4 bullets of what the Health Home is… and then worded different in CCM.

Comprehensive Care Management

- Whole person comprehensive care management. CMS rules indicate oversight of the assessment or just the PCP? Does the assessment need to have direct oversight of the Nurse?
- Page 28 wrap around planning process development and implementation of comingle-based individualized person-centered care plans addressing the needs of the whole child and family, why is that expanded out? Care plan encompasses this. Is there another reason why it is written that way? Calls out child.

Care Coordination

Health Promotion

Individual and Family Support

Referral to Community and Social Support

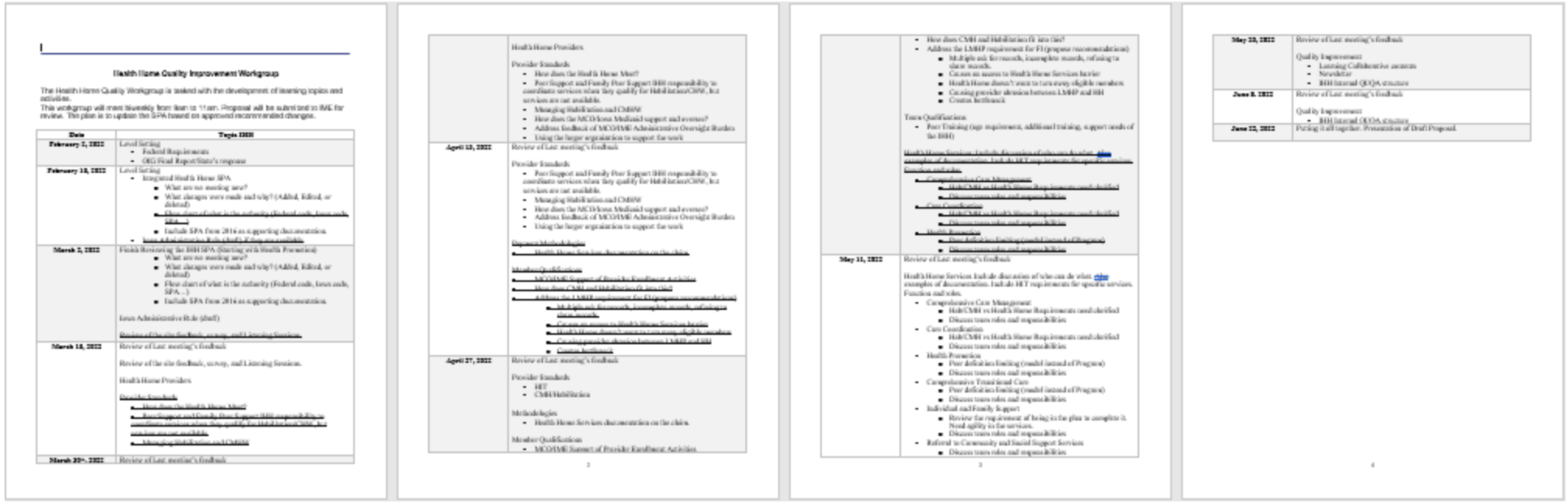
Quality Improvement

Conclusion and Next Steps

Process Improvement Recommendations

- Simplify documentation

Overview of the Timeline



Health Home Quality Improvement Workgroup

The Health Home Quality Workgroup is tasked with the development of learning topics and activities.
This workgroup will meet biweekly from 9am to 11am. Proposal will be submitted to IME for review. The plan is to update the SPA based on approved recommended changes.

Date	Topic IHH
February 2, 2022	Level Setting • Federal Requirements • OIG Final Report/State's response
February 16, 2022	Level Setting • Integrated Health Home SPA ▪ What are we meeting now? ▪ What changes were made and why? (Added, Edited, or deleted) ▪ Flow chart of what is the authority (Federal code, Iowa code, SPA…) ▪ Include SPA from 2016 as supporting documentation. • Iowa Administrative Rule (draft) if they are available.
March 2, 2022	Finish Reviewing the IHH SPA (Starting with Health Promotion) ▪ What are we meeting now? ▪ What changes were made and why? (Added, Edited, or deleted) ▪ Flow chart of what is the authority (Federal code, Iowa code, SPA…) ▪ Include SPA from 2016 as supporting documentation. Iowa Administrative Rule (draft) Review of the site feedback, survey, and Listening Sessions.
March 16, 2022	Review of Last meeting's feedback Review of the site feedback, survey, and Listening Sessions. Health Home Providers Provider Standards ▪ How does the Health Home Meet? ▪ Peer Support and Family Peer Support IHH responsibility to coordinate services when they qualify for Habilitation/CHW, b/c services are not available. ▪ Managing Habilitation and CMHW
March 30th, 2022	Review of Last meeting's feedback

	Health Home Providers Provider Standards ▪ How does the Health Home Meet? ▪ Peer Support and Family Peer Support IHH responsibility to coordinate services when they qualify for Habilitation/CHW, b/c services are not available. ▪ Managing Habilitation and CMHW ▪ How does the MCO/Iowa Medicaid support and oversee? ▪ Address feedback of MCO/IME Administrative Oversight Burden ▪ Using the larger organization to support the work
April 13, 2022	Review of Last meeting's feedback Provider Standards ▪ Peer Support and Family Peer Support IHH responsibility to coordinate services when they qualify for Habilitation/CHW, b/c services are not available. ▪ Managing Habilitation and CMHW ▪ How does the MCO/Iowa Medicaid support and oversee? ▪ Address feedback of MCO/IME Administrative Oversight Burden ▪ Using the larger organization to support the work Payment Methodologies ▪ Health Home Services documentation on the claim. Member Qualifications ▪ MCO/IME Support of Provider Enrollment Activities ▪ How does CMH and Habilitation fit into this? ▪ Address the LMHP requirement for FI (propose recommendation) ▪ Multiple ask for records, incomplete records, refusing to share records. ▪ Causes an access to Health Home Services barrier ▪ Health Home doesn't want to turn away eligible members ▪ Causing provider aversion between LMHP and HH ▪ Creates bottleneck
April 27, 2022	Review of Last meeting's feedback Provider Standards ▪ HIT ▪ CMH/Habilitation Methodologies ▪ Health Home Services documentation on the claim. Member Qualifications ▪ MCO/IME Support of Provider Enrollment Activities

	▪ How does CMH and Habilitation fit into this? ▪ Address the LMHP requirement for FI (propose recommendation) ▪ Multiple ask for records, incomplete records, refusing to share records. ▪ Causes an access to Health Home Services barrier ▪ Health Home doesn't want to turn away eligible members ▪ Causing provider aversion between LMHP and HH ▪ Creates bottleneck Team Qualifications ▪ Peer Training (age requirement, additional training, support needs of the IHH) Health Home Services: Include discussion of who can do what, plus examples of documentation. Include HIT requirements for specific services. Function and roles. ▪ Comprehensive Care Management ▪ HoH/CMH vs Health Home Requirements need clarified ▪ Discuss team roles and responsibilities ▪ Care Coordination ▪ HoH/CMH vs Health Home Requirements need clarified ▪ Discuss team roles and responsibilities ▪ Health Promotion ▪ Peer definition limiting (needs Instead of Program) ▪ Discuss team roles and responsibilities
May 11, 2022	Review of Last meeting's feedback Health Home Services: Include discussion of who can do what, plus examples of documentation. Include HIT requirements for specific services. Function and roles. • Comprehensive Care Management ▪ HoH/CMH vs Health Home Requirements need clarified ▪ Discuss team roles and responsibilities • Care Coordination ▪ HoH/CMH vs Health Home Requirements need clarified ▪ Discuss team roles and responsibilities • Health Promotion ▪ Peer definition limiting (needs Instead of Program) ▪ Discuss team roles and responsibilities • Comprehensive Transitional Care ▪ Peer definition limiting (needs Instead of Program) ▪ Discuss team roles and responsibilities • Individual and Family Support ▪ Review the requirement of being in the plan to complete it. Need agility in the services. ▪ Discuss team roles and responsibilities • Referral to Community and Social Support Services ▪ Discuss team roles and responsibilities

May 25, 2022	Review of Last meeting's feedback Quality Improvement ▪ Learning Collaborative sessions ▪ Newsletter ▪ IHH Internal QI/QA structure
June 8, 2022	Review of Last meeting's feedback Quality Improvement ▪ IHH Internal QI/QA structure
June 22, 2022	Putting it all together. Presentation of Draft Proposal.

Documents for Today

Department of HUMAN SERVICES

Integrated Health Hom

January 2022

Consolidated Implementation Guide
Medicaid State Plan – Health Homes

i

11 Health Home Core Functions

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services.
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
- Coordinate and provide access to mental health and substance abuse services.
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
- Coordinate and provide access to long-term care supports and services.
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
- Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Delivery System Principles

- Demonstrate clinical competency for serving the complex needs of health home enrollees using evidence-based protocols.
- Demonstrate the ability for effectively coordinating the full range of medical, behavioral health, long-term services and supports, and social services for medically complex individuals with chronic conditions.
- Provide health home services that operate under a "whole-person" approach to care using a comprehensive needs assessment and an integrated person-centered care planning process to coordinate care.
- Have conflict of interest safeguards in place to assure enrollee rights and protections are not violated, and that services are coordinated in accordance with enrollee needs expressed in the person-centered care plan, rather than based on financial interests or arrangements of the health home provider.
- Provide access to timely health care 24 hours a day, 7 days a week to address any immediate care needs of their health home enrollees.
- Have in place operational protocol, as well as communication procedures to assure care coordination across all elements of the health care system (hospitals, specialty providers, social service providers, other community-based settings, etc.).
- Have protocols for ensuring safe care transitions, including established agreements and relationships with hospitals and other community-based settings.
- Establish a continuous quality improvement program that includes a process for collection and reporting of health home data for quality monitoring and program performance; permits evaluation of increased coordination and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
- Use data for population health management, tracking tests, referrals and follow-up, and medication management.
- Use health information technology to link services and facilitate communication among interdisciplinary team members and other providers to coordinate care and improve service delivery across the care continuum.

Provider Standards

Health Information Technology

- Use health information technology to link services and facilitate communication among interdisciplinary team members and other providers to coordinate care and improve service delivery across the care continuum.
  - Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate.

Federal Rule Language

A proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider

Use of health information technology to link services, as feasible and appropriate

SMDL

- CMS recognizes the importance of health information technology in furthering the aims of the health home model of service delivery. While States have the flexibility to determine how to use health information technology in their health home models, CMS encourages States to consider utilizing technologies to provide health home services and improve care coordination across the care continuum.
- CMS recognizes the importance of health information technology in furthering the aims of the health home model of service delivery. While States have the flexibility to determine how to use health information technology in their health home models, CMS encourages States to consider utilizing technologies to provide health home services and improve care coordination across the care continuum.
- Monitor the use of health information technology to improve service delivery and coordination across the care continuum (including the use of wireless patient technology in improving coordination, management of care, and patient adherence to recommendations made by their providers).

West Virginia

The health home provider must use an electronic health record system that qualifies under the Meaningful use Provisions of the HITECH Act which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. Providers may also access The West Virginia Health Information Network (WVHIN), which is an interactive network.

As the use of HIT and the implementation of a statewide health information exchange evolve, it is anticipated that the use of HIT to support all of the health homes services will also evolve.

SWIFT-022120174060-FinalResponse-WV SPA 16-0007 HH Approval Letter.pdf

Microsoft Word - WV Health Home Provider Standards V1.0 04302014.docx

Minnesota

Utilize an electronic health record (EHR).

Use a patient registry to inform population management strategies, identify and manage care gaps, and facilitate communication among BHH services team members. Systematically use the patient registry to identify specific population subgroups requiring specific levels or types of care. The BHH services patient registry must contain sufficient elements to issue a report that shows gaps in care and needs for individuals and populations or population subgroups.

DHS-6766 - BHH Services (state.mn.us)

South Dakota

Health Home providers must have completed Electronic Health Record (EHR) implementation and use the EHR as its primary medical record solution, prior to becoming a Health Home provider. Health Home providers must electronically report to the State (in a manner defined by the Department of Social Services) information about how the Core Services are being met and the outcome measures.

SD-13-0008.pdf (medicaid.gov)

ICM

Habilitation and CMH Waiver

What should be included to articulate Standards for the ICM population?

How should Habilitation and CMHW be incorporated?

Payment Methodologies

Caseload Assumptions

- Informed by:
  - Iowa Provider Data (Staffing Models Provided by Health Homes)
  - Best Practice Research
  - Prior Methodology used for benchmarking

- Updated to reflect IME's preferred caseload allocation based on population needs
- Varies based on role, age cohort, and tier

Staffing Cost Assumptions

- Updated salary/wage with most recent Bureau of Labor Statistics (BLS) data (CY2018)
- Gross up for other costs (Benefits, Indirect costs)
- Split into two categories:
  - Caseload Staff (based on caseload)
  - Program Level Staff allocated across tiers based on enrollment distribution
- Budget Neutrality

Program-Level Staff	Caseload Staff
Director	Nurse Care Manager
Supervisor	Care Coordinator
	Peer Support Specialist

Optumas

Integrated Health Home: Wages from https://www.iowaworkforcedevelopment.gov/iowa-wage-report

Practice Staff	Mean Wage per FTE
Nurse Care Manager (RN/BSN)	$57,927
Case Manager (Mental Health and Substance Abuse Social Workers)	$45,753
Peer/ Family Peer Support Specialist (Community Health Workers)	$39,513
Supervisor (Medical and Health Services Manager)	$86,712
Project Manager (Managers, all other)	$92,258

Rate Considerations from Survey

- Staffing Ratio
- Other
  - The gap between IHH and ICM requirements has narrowed with both populations requiring a significant amount of intensive work
  - Quality Assurance & Quality Improvement are needed
- Current Staff Wages and Benefits
  - Competitive Wages and benefits
- Risk of members

Next Steps

- Review of this meeting's feedback
- Review Updated Workgroup Report
- Continue discussions on Rate Methodology and Billing
- Member Requirements
- Provider Requirements